STATE OF ARIZONA
FILED

JUN 29 2012

DEPT. OF INSURANCE

REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

HALLMARK INSURANCE COMPANY

NAIC #34037

AS OF

DECEMBER 31, 2010

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Honorable Christina Urias
Director of Insurance
State of Arizona
2910 North 44th Street
Suite 210, Second Floor
Phoenix, Arizona 85108-7269

Dear Director Urias:

Pursuant to your instructions and in conformity with the provisions of the Insurance Laws and Rules of the State of Arizona, an examination has been made of the market conduct affairs of the:

HALLMARK INSURANCE COMPANY
NAIC # 34037

The above examination was conducted by William Hobert, Examiner-in-Charge, and Market Conduct Insurance Examiner Robert DeBerge.

The examination covered the period of January 1, 2010 through December 31, 2010.

As a result of that examination, the following Report of Examination is respectfully submitted.

Sincerely yours,

Helene I. Tomme

Helene I. Tomme, CPCU, CIE
Market Conduct Examinations Supervisor
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

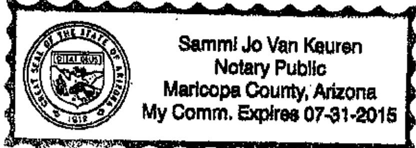
William P. Hobert being first duly sworn, states that I am a duly appointed Market Conduct Examinations Examiner-in-Charge for the Arizona Department of Insurance. That under my direction and with my participation and the participation of Market Conduct Insurance Examiner Robert DeBerge on the Examination of Hallmark Insurance Company, hereinafter referred to as the "Company" was performed at the examiners' residences. A teleconference meeting with appropriate Company officials was held to discuss this Report, but a copy was not provided to management as the Examination was incomplete and had not yet been finalized. The information contained in this Report, consists of the following pages, is true and correct to the best of my knowledge and belief and that any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.

William P. Hobert, CPCU, CLU, CIE
Market Conduct Examiner-in-Charge
Market Oversight Division

Subscribed and sworn to before me this 01 day of March, 2012.

Notary Public

My Commission Expires 07/31/2015



FOREWORD

This target market conduct examination report of Hallmark Insurance Company (herein referred to as the "Company"), was prepared by employees of the Arizona Department of Insurance (Department) as well as independent examiners contracting with the Department. A target market conduct examination is conducted for the purpose of auditing certain business practices of insurers licensed to conduct the business of insurance in the state of Arizona. The examiners conducted the examination of the Company in accordance with Arizona Revised Statutes (A.R.S.) §§ 20-142, 20-156, 20-157, 20-158 and 20-159. The findings in this report, including all work product developed in the production of this report, are the sole property of the Department.

The examination consisted of a review of the following Private Passenger Automobile (PPA) business operations:

1. Complaint Handling
2. Marketing and Sales
3. Producer Compliance
4. Underwriting and Rating
5. Declinations, Cancellations and Non-Renewals
6. Claims Processing

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Director.

Failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department.

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. The target market conduct examination of the Company covered the period of

January 1, 2010 through December 31, 2010 for business reviewed. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws, and whether the Company's operations and practices are consistent with the public interest. This examination was completed by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report and the results are reported beginning on page 7.

In accordance with Department procedures, the examiners completed a Preliminary Finding ("Finding") form on those policies, claims and complaints not in apparent compliance with Arizona law. The finding forms were submitted for review and comment to the Company representative designated by Company management to be knowledgeable about the files. For each finding the Company was requested to agree, disagree or otherwise justify the Company's noted action.

The examiners utilized both examinations by test and examination by sample. Examination by test involves review of all records within the population, while examination by sample involves the review of a selected number of records from within the population. Due to the small size of some populations examined, examinations by test and by sample were completed without the need to utilize computer software.

File sampling was based on a review of underwriting and claim files that were systematically selected by using Audit Command Language (ACL) software and computer data files provided by the Company. Samples are tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data will result in an exception ratio, which determines whether or not a standard is met. If the exception ratio found in the sample is, generally less than 5%, the standard will be considered as "met." The standard in the areas of procedures and forms use will not be met if any exception is identified.

HISTORY OF THE COMPANY

The Company was originally incorporated as Phoenix Indemnity Insurance Company (PIIC) under the laws of Arizona on 6/20/88. As a subsidiary of Acceptance Insurance Company, the Company commenced business 8/23/88. PIIC was acquired by Millers American Group 9/20/99. In January 2003, PIIS was sold to Hallmark Financial Services, Inc. (HFS). Since 12/31/03, the Company has been party to a management services agreement with American Hallmark General Agency, Inc (AHGA) to provide management, marketing,

administrative, accounting, legal, investment, actuarial, payroll and other employee related benefit administration. A similar agreement with Hallmark Claim Services, Inc. (HCS) provides the Company claim handling services. The Company adopted its current name in February 2008. HFS owns all Company stock and is traded on the NASDAQ, symbol HALL.

The Company's statutory home office is 8601 North Scottsdale Road, Suite 300, Scottsdale, AZ 85253. The main administrative office and primary location of books and records is 777 Main Street, Suite 1000, Fort Worth, TX 76102. The Company maintains private passenger automobile (PPA) licensing in twenty-seven (27) states.

PROCEDURES REVIEWED WITHOUT EXCEPTION

The examiners' review of the following Company departments[1] or functions indicates that they appear to be in compliance with Arizona statutes and rules:

Complaint Handling　　Marketing and Sales　　Producer Compliance

EXAMINATION REPORT SUMMARY

The examination revealed seventeen (17) compliance issues that resulted in 274 exceptions due to the Company's failure to comply with statutes and rules that govern all insurers operating in Arizona. These issues were found in three (3) of the six (6) sections of Company operations examined. The following is a summary of the examiners' findings:

Underwriting and Rating

In the area of Underwriting and Rating, four (4) compliance issues are addressed in this report as follows:

- The Company failed to accurately document and apply surcharges (i.e. points) used to determine premium for five (5) PPA policies.
- The Company failed to provide a Summary of Rights to fourteen (14) insureds when their policy premiums increased due to an adverse underwriting decision.
- The Company's disclosure authorization contained in the application failed to:
  (a) limit the length of time the authorization for personal or privileged information used in the underwriting process remains valid to no longer than one (1) year; and

(b) inform the individual or a person authorized to act on behalf of the individual that they both are entitled to receive a copy of the authorization form.

Declinations, Cancellations and Non-Renewals

In the area of Cancellations and Non-renewals, three (3) compliance issues are addressed in this report as follows:

- The Company failed to provide a Summary of Rights to all fifty (50) insureds that had their policies cancelled and to the only recipient of a non-renewal.
- The Company failed to include the unearned premium refund with the policy cancellation notice to fifty (50) policyholders.
- The Company failed to provide three (3) insureds a cancellation notice mailed at least ten (10) days prior to the date of cancellation.

Claims Processing

In the area of Claims Processing, ten (10) compliance issues are addressed in this report as follows:

- The Company failed to provide a fraud warning statement:
  (a) on two (2) claim forms, and
  (b) on seven (7) claim forms in at least twelve (12) point type,
- The Company failed to specify on two (2) claim authorization forms the types of persons authorized to disclose information about the individual.
- The Company failed to specify on two (2) claim authorization forms that the authorization shall remain valid for no longer than the duration of the claim.
- The Company failed to advise on two (2) claim authorization forms that the individual or a person authorized to act on behalf of the individual are entitled to receive a copy of the authorization form.
- The Company failed to correctly calculate and fully pay:
  (a) sales tax owed to sixteen (16) first and twenty-eight (28) third party total loss claimants; and

[1] If a department name is listed there were no exceptions noted during the review.

(b) fees owed on twenty-one (21) first and forty-one (41) third party total loss settlements.

- The Company failed to consistently apply unrelated prior damage adjustments with five (5) first and fourteen (14) third party total loss settlements.
- The Company failed to adequately document salvage allowances taken with two (2) third party owner retained total loss settlements.
- The Company failed to provide eight (8) first party claimants a denial in writing or include the specific policy provision, condition or exclusion in the denial letters.

FACTUAL FINDINGS

RESULTS OF PREVIOUS MARKET EXAMINATIONS

During the past three (3) years, the Company had no market conduct examinations conducted by any jurisdiction.

FACTUAL FINDINGS

UNDERWRITING AND RATING

Private Passenger Automobile (PPA):

The examiners reviewed:

(1) 100 PPA new business and/or renewal policies from a population of 50,989; and
(2) fifty (50) PPA surcharged policies from a population of 3,279.

The following Underwriting and Rating Standards were met:

#	STANDARD	Regulatory Authority
4	All forms and endorsements forming a part of the contract should be filed with the director (if applicable).	A.R.S. § 20-398
5	Policies and endorsements are issued or renewed accurately, timely and completely.	A.R.S. §§ 20-1120, 20-1121
6	Rescissions are not made for non-material misrepresentations.	A.R.S. §§ 20-463, 20-1109

The following Underwriting and Rating Standard failed:

#	STANDARD	Regulatory Authority
1	The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the Company Rating Plan.	A.R.S. §§ 20-341 through 20-385

Preliminary Findings #11 – Undocumented Premium Surcharges - The Company failed to accurately document and apply surcharges (i.e. points) used to determine premium for five (5) surcharged PPA policies. These represent five (5) violations of A.R.S. § 20-385.

PPA NEW / RENEWAL AND SURCHARGED POLICIES
Failed to accurately document and apply surcharges (i.e. points) to determine premium
Violation of A.R.S. § 20-385

Population	Sample	# of Exceptions	% to Sample
50,989	62	5	8%

An 8% error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #1

Within ninety (90) days of the filed date of this report, provide the Department with documentation that Company procedures and controls are in place to ensure the Company's use of premium surcharges (i.e. points) is accurately documented and applied, in accordance with the Company's filed rates and state statutes.

The following Underwriting and Rating Standard failed:

#	STANDARD	Regulatory Authority
2	Disclosures to insureds concerning rates and coverage are accurate and timely.	A.R.S. §§ 20-259.01, 20-262, 20-263, 20-264, 20-266, 20-267, 20-2110

Preliminary Finding #14 – No Summary of Rights - The Company failed to provide a Summary of Rights to all fourteen (14) insureds that had policy premiums increased due to an adverse underwriting decision. These represent fourteen (14) violations of A.R.S. § 20-2110(A).

PPA NEW / RENEWAL AND SURCHARGED POLICIES

Failed to provide Summary of Rights when premium increase due to adverse underwriting action

Violation of A.R.S. § 20-2110(A)

Population	Sample	# of Exceptions	% to Sample
50,989	14	14	100%

A 100% error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #2

Within ninety (90) days of the filed date of this report, provide the Department with documentation that Company procedures and controls are in place to ensure the Company provides a Summary of Rights, in accordance with the statutes, to any insured when a premium increase results from an adverse underwriting decision.

Subsequent Event

Before the close of the exam, the Company adopted the Department's recommended Summary of Rights form on Company letterhead (AZ SOR 2012-02).

The following Underwriting and Rating Standard failed:

#	STANDARD	Regulatory Authority
3	All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations, including, but not limited to, the Notice of Insurance Information Practices and the Authorization for Release of Information.	A.R.S. §§ 20-2104, 20-2106, 20-2110, 20-2113

Preliminary Finding #13 – Underwriting Authorization - On the Company's PPA application (no form #), the Company failed to:

(a) specify the authorization remains valid for no longer than one (1) year from the date the authorization is signed; and

(b) advise the individual or a person authorized to act on behalf of the individual that they are entitled to receive a copy of the authorization form.

This form fails to comply with A.R.S. § 20-2106(7)(b) and (9) and represents two (2) violations of the statute.

UNDERWRITING FORMS

Failed to specify the authorization remains valid for no longer than one (1) year from date signed
Violation of A.R.S. § 20-2106(7)(b)

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	1	N/A

Any form error does not meet the Standard; therefore a recommendation is warranted.

Failed to advise the individual or a person authorized to act on behalf of the individual that they are entitled to receive a copy of the authorization form
Violation of A.R.S. § 20-2106(9)

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	1	N/A

Any form error does not meet the Standard; therefore a recommendation is warranted.

Subsequent Event
Before the close of the exam, the Company provided the examiners a copy of its corrected PPA application (AZ HIC APP 2012-03).

FACTUAL FINDINGS

DECLINATIONS, CANCELLATIONS AND NON-RENEWALS

Private Passenger Automobile (PPA):

The examiners reviewed:

(1) 100 PPA non-payment cancellations from a population of 10,962;
(2) fifty (50) PPA cancellations for underwriting reason from a population of 615; and
(3) the only non-renewal.

The following Declination, Cancellation and Non-Renewal Standard failed:

#	STANDARD	Regulatory Authority
1	Declinations, Cancellations and Non-Renewals shall comply with state laws and Company guidelines including the Summary of Rights to be given to the applicant and shall not be unfairly discriminatory.	A.R.S. §§ 20-448, 20-2108, 20-2109 and 20-2110

Preliminary Findings #7 – No Summary of Rights - The Company failed to provide a Summary of Rights with all fifty (50) underwriting cancellation notices and the only non-renewal notice. These represent a total of fifty-one (51) violations of A.R.S. § 20-2110.

PPA CANCELLATION AND NON-RENEWALS

Failed to provide a Summary of Rights to insureds receiving a cancellation or non-renewal notice
Violation of A.R.S. § 20-2110

Population	Sample	# of Exceptions	% to Sample
616	51	51	100%

A 100% error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #3

Within ninety (90) days of the filed date of this report, provide the Department with documentation that Company procedures and controls are in place to ensure a Summary of Rights is provided to all insureds, in accordance with the applicable statutes, when their policies are cancelled and non-renewed due to an adverse underwriting decision.

Subsequent Event

Before the close of the exam, the Company provided the examiners, on Company letterhead, a copy of the Department's recommended Summary of Rights form (AZ SOR 2012-02).

The following Declination, Cancellation and Non-Renewal Standard failed:

#	STANDARD	Regulatory Authority
2	Cancellations and non-renewal notices comply with state laws, Company guidelines and policy provisions, including the amount of advance notice required and grace period provisions to the policyholder, and shall not be unfairly discriminatory.	A.R.S. §§ 20-191, 20-443, 20-448, 20-1631, 20-1632, 20-1632.01

Preliminary Findings #8 – Late Unearned Premium Refunds - The Company failed to include the unearned premium refund with the policy cancellation notice sent to all fifty (50) policyholders owed a refund. These represent fifty (50) violations of A.R.S. § 20-1632(A)(3).

PPA CANCELLATIONS

Failed to include the unearned premium refund with the policy cancellation notice
Violation of A.R.S. § 20-1632(A)(3)

Population	Sample	# of Exceptions	% to Sample
615	50	50	100%

A 100% error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #4

Within ninety (90) days of the filed date of this report, provide the Department with documentation that Company procedures and controls are in place to ensure Company payment of any unearned premium accompanies all policy termination notices as needed, in accordance with the applicable statutes.

Preliminary Findings #10 – Late Cancellation Notices - The Company failed to provide three (3) insureds a cancellation notice mailed at least ten (10) days before the cancellation was to be effective. These represent three (3) violations of A.R.S. § 20-1632(A).

PPA CANCELLATIONS

Failed to provide cancellation notice at least ten (10) days before cancellation effective date
Violation of A.R.S. § 20-1632(A)

Population	Sample	# of Exceptions	% to Sample
615	50	3	6%

A 6% error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #5

Within ninety (90) days of the filed date of this report, provide the Department with documentation that Company procedures and controls are in place to ensure Company mails cancellation notices at least ten (10) days before the cancellation is effective, in accordance with the applicable statutes.

FACTUAL FINDINGS

CLAIM PROCESSING

Private Passenger Automobile (PPA):

The examiners reviewed:

(1) fifty (50) PPA claims closed without payment from a population of 575;
(2) fifty (50) PPA claims paid from a population of 606;
(3) all sixty-two (62) PPA total losses; and
(4) all thirteen (13) PPA subrogations.

The following Claim Processing Standards were met:

#	STANDARD	Regulatory Authority
1	The initial contact by the Company with the claimant is within the required time frame.	A.R.S. § 20-461, A.A.C. R20-6-801
2	Timely investigations are conducted.	A.R.S. § 20-461, A.A.C. R20-6-801
4	Claim files are adequately documented in order to be able to reconstruct the claim.	A.R.S. §§ 20-461, 20-463, 20-466.03, A.A.C. R20-6-801
6	The Company uses reservation of rights and excess of loss letters, when appropriate.	A.R.S. § 20-461, A.A.C. R20-6-801
8	The Company responds to claim correspondence in a timely manner.	A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801
10	No insurer shall fail to fully disclose to first party insureds all pertinent benefits, coverages, or other provisions of an insurance policy or insurance contract under which a claim is presented.	A.A.C. R20-6-801
11	Adjusters used in the settlement of claims are properly licensed.	A.R.S. §§ 20-321 through 20-321.02

The following Claim Processing Standard failed:

#	STANDARD	Regulatory Authority
3	The Company's claim forms are appropriate for the type of product and comply with statutes, rules and regulations.	A.R.S. §§ 20-461, 20-466.03, 20-2106, A.A.C. R20-6-801

Preliminary Finding #2 – Fraud Warning Statement - The Company failed to provide a fraud warning statement on two (2) claim forms and failed to provide the statement in at least twelve (12) point type on seven (7) claim forms. These represent nine (9) violations of A.R.S. § 20-466.03.

	Form Title / Description	Form #	Reason	Found in...
1	Medical Authorization-HIPPA	None	No Fraud Warning	Att. A Forms
2	Release and Indemnity Agreement	None	Less than 12 Point Type	PDT-01
3	Cooperation Recorded Statement	None	Less than 12 Point Type	Att A Forms
4	Ack Letter of Atty. Representation	None	Less than 12 Point Type	Att A Forms
5	Lost Wages to Employer	None	Less than 12 Point Type	Att A Forms
6	Settlement Letter with Release	None	Less than 12 Point Type	Att A Forms
7	Pre-Suit Letter	None	Less than 12 Point Type	Att A Forms
8	Request for Medical Authorization	None	Less than 12 Point Type	Att A Forms
9	General Release and Indemnification	None	No Fraud Warning	PDT-10

CLAIM FORMS

Failed to provide fraud warning as required by statute

Violation of A.R.S. § 20-466.03

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	9	N/A

Any error does not meet the Standard; therefore a recommendation is warranted.

Subsequent Event

Before the close of the exam, the examiners received copies of thirty-three (33) claim letters and/or forms corrected by the Company to contain the fraud warning in required size type. Each of the nine (9) items criticized by the examiners were corrected.

Preliminary Finding #3 – Authorization Disclosures – On two (2) claim authorization forms shown in the table below, the Company failed to:

(a) specify the types of persons authorized to disclose information about the individual;
(b) specify the authorization remains valid for no longer than the duration of the claim; and
(c) advise the individual or a person authorized to act on behalf of the individual that they are entitled to receive a copy of the authorization form.

These forms fail to comply with A.R.S. § 20-2106(3), (8)(b) and (9) and represent six (6) violations of the statute. The following table summarizes these authorization form findings.

Form Description / Title	Form #	Statute Provision
Medical Authorization Form – HIPPA	None	3, 8(b) and 9
Wage Authorization Form	None	3, 8(b) and 9

CLAIM FORMS

Failed to specify the types of persons authorized to disclose information about the individual

Violation of A.R.S. § 20-2106(3)

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	2	N/A

Any form error does not meet the Standard; therefore a recommendation is warranted.

Failed to specify the authorization remains valid for no longer than the duration of the claim
Violation of A.R.S. § 20-2106(8)(b)

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	2	N/A

Any form error does not meet the Standard; therefore a recommendation is warranted.

Failed to advise the individual or a person authorized to act on behalf of the individual that they are entitled to receive a copy of the authorization form
Violation of A.R.S. § 20-2106(9)

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	2	N/A

Any form error does not meet the Standard; therefore a recommendation is warranted.

Subsequent Event
Before the close of the exam, the Company provided the examiners corrected copies of both forms.

The following Claim Processing Standard failed:

#	STANDARD	Regulatory Authority
5	Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	A.R.S. §§ 20-268 20-461, 20-462, 20-468, 20-469, A.A.C. R20-6-801

Preliminary Findings #4 and #5 – Total Loss Sales Tax and Fees – The Company failed to accurately calculate and fully pay the correct:

(a) sales tax with sixteen (16) first and twenty-eight (28) third party total loss settlements; and
(b) fees with twenty-one (21) first and forty-one (41) third party total loss settlements.

These represent a total of 106 violations of A.R.S. § 20-461(A)(6) and A.A.C. R20-6-801(H)(1)(b).

PPA TOTAL LOSSES

Failed to correctly calculate and pay sales taxes and fees associated with total loss settlements.
Violation of A.R.S. § 20-461(A)(6), A.A.C. R20-6-801(H)(1)(b)

Population	Sample	# of Exceptions	% to Sample
62	62	106	100%

A 100% error ratio does not meet the Standard; therefore a recommendation is warranted.

__Recommendation #6__

Within ninety (90) days of the filed date of this report, provide documentation to the Department that procedures and controls are in place to ensure the Company correctly calculates and fully pays any sales tax and title, registration or other fees, owed any claimant in the settlement of a total loss, in accordance with applicable state statutes and regulations. In addition, the Company should make restitution to these claimants, including interest, and provide the Department appropriate documentation of payments. With each payment of restitution, provide a letter indicating that an audit of claims by the Department resulted in identification and correction of previous claim payment.

Preliminary Finding #6 – Inconsistent Unrelated Prior Damage Adjustments – The Company failed to consistently calculate unrelated prior damage amounts used to determine Actual Cash Value (ACV) of five (5) first and fourteen (14) third party total loss settlements. These represent a total of nineteen (19) violations of A.R.S. § 20-461(A)(6) and A.A.C. R20-6-801(H)(1)(c).

PPA TOTAL LOSSES

Failed to consistently calculate unrelated prior damage amounts with total loss settlements.
Violation of A.R.S. § 20-461(A)(6), A.A.C. R20-6-801(H)(1)(c)

Population	Sample	# of Exceptions	% to Sample
28	28	19	67.9%

A 67.9% error ratio does not meet the Standard; therefore a recommendation is warranted.

__Recommendation #7__

Within ninety (90) days of the filed date of this report, provide documentation to the Department that procedures and controls are in place to ensure the Company consistently calculates and applies unrepaired prior damage to determine Actual Cash Value (ACV) with PPA total loss settlements, in accordance with applicable state statutes and regulations.

Preliminary Finding #6 – Undocumented Salvage Allowances – The Company failed to adequately document salvage allowances taken with two (2) third party owner retained total loss settlements. These represent two (2) violations of A.R.S. § 20-461(A)(6) and A.A.C. R20-6-801(C).

PPA TOTAL LOSSES

Failed to adequately document salvage allowances with total loss settlements.
Violation of A.R.S. § 20-461(A)(6), A.A.C. R20-6-801(C)

Population	Sample	# of Exceptions	% to Sample
5	5	2	40%

A 40% error ratio does not meet the Standard; therefore a recommendation is warranted.

Recommendation #8
Within ninety (90) days of the filed date of this report, provide documentation to the Department that procedures and controls are in place to ensure the Company adequately documents salvage allowances used to determine Actual Cash Value (ACV) with any owner retained total loss settlement, in accordance with applicable state statutes and regulations.

The following Claim Processing Standard failed:

#	STANDARD	Regulatory Authority
9	Denied and closed without payment claims are handled in accordance with policy provisions and state law.	A.R.S. §§ 20-461, 20-462, 20-463, 20-466, 20-2110, A.A.C. R20-6-801

Preliminary Finding #1 – Written Claim Denial – The Company failed to provide eight (8) first party claimants a denial in writing or include the specific policy provision, condition or exclusion in the denial letters. These represent eight (8) violations of A.R.S. § 20-461(A)(5) and A.A.C. R20-6-801(G)(1)(a).

PPA CLAIMS CLOSED WITHOUT PAYMENT
Failed to provide first party claimants written claim denial with reference to specific policy provision, condition or exclusion
Violation of A.R.S. § 20-461(A)(5) and A.A.C. R20-6-801(G)(1)(a)

Population	Sample	# of Exceptions	% to Sample
575	50	8	16%

An 16% error ratio does not meet the Standard; therefore a recommendation is warranted

Recommendation #9
Within ninety (90) days of the filed date of this report, provide documentation to the Department that procedures and controls are in place to ensure the Company provides all claimants a written explanation of the Company's claim denial, in accordance with applicable state statute.

SUMMARY OF FAILED STANDARDS

EXCEPTION	Rec. No.	Page No.
UNDERWRITING & RATING		
Standard #1 The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the Company Rating Plan.	1	12
Standard #2 Disclosures to insureds concerning rates and coverage are accurate and timely.	2	13
Standard #3 All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations, including, but not limited to, the Notice of Insurance Information Practices and the Authorization for Release of Information.	N/A	14
DECLINATIONS, CANCELLATIONS & NON-RENEWALS		
Standard #1 Declinations, Cancellations and Non-Renewals shall comply with state laws and Company guidelines including the Summary of Rights to be given to the applicant and shall not be unfairly discriminatory.	3	16
Standard #2 Cancellations and non-renewal notices comply with state laws, Company guidelines and policy provisions, including the amount of advance notice required and grace period provisions to the policyholder, and shall not be unfairly discriminatory.	4 & 5	17
CLAIM PROCESSING		
Standard #3 The Company claim forms are appropriate for the type of product and comply with statutes, rules and regulations.	N/A	20 & 21
Standard #5 Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	6, 7 & 8	22 & 23
Standard #9 Denied and closed without payment claims are handled in accordance with policy provisions and state law.	9	23

SUMMARY OF PROPERTY AND CASUALTY STANDARDS

A. Complaint Handling

#	STANDARD	PASS	FAIL
1	The Company takes adequate steps to finalize and dispose of the complaints in accordance with applicable statutes, rules, regulations and contract language. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
2	The time frame within which the Company responds to complaints is in accordance with applicable statutes, rules and regulations. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	

B. Marketing and Sales

#	STANDARD	PASS	FAIL
1	All advertising and sales materials are in compliance with applicable statutes, rules and regulations. (A.R.S. §§ 20-442 and 20-443)	X	

C. Producer Compliance

#	STANDARD	PASS	FAIL
1	The producers are properly licensed in the jurisdiction where the application was taken. (A.R.S. §§ 20-282, 20-286, 20-287, 20-311 through 311.03)	X	
2	An insurer shall not pay any commission, fee, or other valuable consideration to unlicensed producers. (A.R.S. § 20-298)	X	

D. Underwriting and Rating

#	STANDARD	PASS	FAIL
1	The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the Company Rating Plan. (A.R.S. §§ 20-341 through 20-385)		X
2	Disclosures to insureds concerning rates and coverage are accurate and timely. (A.R.S. §§ 20-259.01, 20-262, 20-263, 20-264, 20-266, 20-267, 20-2110)		X

#	STANDARD	PASS	FAIL
3	All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations, including, but not limited to, the Notice of Insurance Information Practices and the Authorization for Release of Information. (A.R.S. §§ 20-157, 20-2104, 20-2106, 20-2110 and 20-2113)		X
4	All forms and endorsements forming a part of the contract should be filed with the director (if applicable). (A.R.S. § 20-398)	X	
5	Policies and endorsements are issued or renewed accurately, timely and completely. (A.R.S. §§ 20-1120 and 20-1121)	X	
6	Rescissions are not made for non-material misrepresentations. (A.R.S. §§ 20-463 and 20-1109)	X	

E. Declinations, Cancellations and Non-Renewals

#	STANDARD	PASS	FAIL
1	Declinations, Cancellations and Non-Renewals shall comply with state laws and Company guidelines including the Summary of Rights to be given to the applicant and shall not be unfairly discriminatory. (A.R.S. §§ 20-448, 20-2108, 20-2109 and 20-2110)		X
2	Cancellations and non-renewal notices comply with state laws, Company guidelines and policy provisions, including the amount of advance notice required and grace period provisions to the policyholder, and shall not be unfairly discriminatory. (A.R.S. §§ 20-191, 20-443, 20-448, 20-1631, 20-1632, 20-1632.01)		X

F. Claim Processing

#	STANDARD	PASS	FAIL
1	The initial contact by the Company with the claimant is within the required time frame. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
2	Timely investigations are conducted. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	

#	STANDARD	PASS	FAIL
3	The Company claim forms are appropriate for the type of product and comply with statutes, rules and regulations. (A.R.S. §§ 20-461, 20-466.03, 20-2106, A.A.C. R20-6-801)		X
4	Claim files are adequately documented in order to be able to reconstruct the claim. (A.R.S. §§ 20-461, 20-463, 20-466.03, A.A.C. R20-6-801)	X	
5	Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations. (A.R.S. §§ 20-268, 20-461, 20-462, 20-468, 20-469, A.A.C. R20-6-801)		X
6	The Company uses reservation of rights and excess of loss letters, when appropriate. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
7	Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)	X	
8	The Company responds to claim correspondence in a timely manner. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)	X	
9	Denied and closed without payment claims are handled in accordance with policy provisions and state law. (A.R.S. §§ 20-461, 20-462, 20-463, 20-466, 20-2110, A.A.C. R20-6-801)		X
10	No insurer shall fail to fully disclose to first party insureds all pertinent benefits, coverages, or other provisions of an insurance policy or insurance contract under which a claim is presented. (A.A.C. R20-6-801)	X	
11	Adjusters used in the settlement of claims are properly licensed. (A.R.S. §§ 20-321 through 20-321.02)	X	